

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  11/13/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, OAK RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 LABORATORY RD OAK RIDGE, TN 37831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  A annual Licensure survey and complaint investigation #33888 were completed on November 10, 2014 through November 13, 2014, at NHC Healthcare Oak Ridge. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

2B9611

If continuation sheet 1 of 1

DEC 05 2014